For various reasons, some of which I shall touch upon, the borderline individual has inordinate difficulty in integrating the experiences of separation and loss which are inherent in human living generally, and in the course of psychoanalytic therapy more specifically. But more than that, his borderline personality-organization

itself renders ever-present, for him, the danger of separation and loss. If we accept (as do I) the finding of Mahler (1968) that the borderline patient’s personality-structure is developmentally traceable to difficulties in the phase of separation and individuation, we see that his tenuously established individual ego faces continually the threat, on the one hand, lest his fear of his separateness impel him into regression into symbiosis with the other person (equivalent, for him, to a symbiotic mother), with consequent total loss of individuality; and the threat, on the other hand, that his fear of such symbiotic fusion will impel him into autism (that is, psychosis) of such degree that he will suffer a loss of any human relatedness.

The Analyst’s Projecting Unconscious Loss-Reactions into the Patient

In beginning, now, a much less than comprehensive discussion of this large subject, I shall mention some aspects of the reactions, on the parts of both the analyst and the patient, to their separation from one another between sessions.

The analyst typically ends each session in a manner that, while intended to be minimally upsetting to the patient, minimizes any feeling of loss which the analyst himself tends to have, at this imminent separation from the patient. Even more, when the analyst announces that he will be away for a day or a week, say, he tends to do this in a calm, matter-of-fact manner—consciously designed, again, to minimize separation-anxiety on the patient’s part—which, again, is easy for the patient to perceive as indicating that the analyst himself feels no loss whatever at the prospect of the forthcoming separation from him. One could surmise, here, that the patient perceives little, if any, evidence that the analyst will miss him at all, or have any thought of him at all, during the forthcoming separation.

Commonly, not only in my own work but in that of supervisees (and other colleagues) about which I hear, this kind of analytic stance tends to represent an appreciable repression of feelings of separation-anxiety and loss on the analyst’s part, as regards such separations. Thus the patient who manifests persistent difficulty in gaining access to such feelings on his own part, during the analyst’s vacations (for example), may well be identifying with the analyst’s own manner of defending against such feelings within himself.

Obviously, the analyst tends to project such feelings into the patient, and look unconsciously to the latter to recognize and express such feelings for both participants.

A woman who had been in analysis with me for several years started speaking, at the beginning of a Monday session, of “My attachment to you—it’s horrendous—You know why Mondays are so blah?—for me?” I inquired, “Why?,” and she replied, “At the beginning of the weekend, you go away and leave, and then it’s as though when you come back on Monday I’ve forgotten you—I’ve dismissed you. I have to, because it’s too painful [to do otherwise]....”

In hearing this, I found interesting what I sensed to be an aspect of her identifying with me, in the transference, for when she said, “...I’ve forgotten you—I’ve dismissed you,” it sounded entirely that she was doing to me what she felt I had done to her. This itself was nothing new or surprising. But then when she went on, “I have to, because it’s too painful [to do otherwise],” it sort of me that she unconsciously fantasized that I had to dismiss and forget her, for otherwise it would be too painful for me. Immediately, while attributing to her an unconscious fantasy of this sort, I sensed there to be an element of reality in her unconscious perception of my defensive dismissing of my own dependency upon her.
The Role, in the Patient’s Acting-Out, of His Unconscious Identifications with Largely Unconscious Attributes of the Analyst

In the instance of patients who tend to become involved, persistently, in self-destructive acting-out between sessions (and especially during the analyst’s prolonged absences), I have found, time and again, that such behavior has, as one of its major determinants, the patient’s introjection of some internal psychological contents of my own (contents which are, as always, partly indeed here in me, but partly attributed to me, unconsciously, by the patient in terms of whom, or what, I represent to him in the transference).

That is, much “self-destructive behavior, on the patient’s part, during my absences, proves on further analysis to have been behavior directed, unconsciously, against the patient’s introjected image of me. Typically, such behavior tends to seem to me maddeningly ego-syntonic for the patient, who comes into the session and reports it in a spirit of vindictive relish, as though he has injured the analyst rather than, or in any case more than, himself.

In Chapter 9, I discussed some of the difficulties involved in the borderline patient’s development of an internalized image of the therapist. It may be, indeed, that we are working with a patient who has not yet developed an enduring internalized image of the analyst. But, much more often, the patient has introjected various aspects of our largely-unconscious personality-attributes, and is manifesting, between sessions, various identifications with us, identifications which, from our vantage-point, are so disguised as to be unrecognizable as such for prolonged periods of time, all the more so insofar as these consist in identifications with attributes of ourself not merely distortedly perceived by the patient who is in the grip of powerful transference-reactions to us, but also highly unpalatable to our conscious sense of our own identity. The more ill the patient is, the more does he tend to identify, earliest, with the analyst's own sickest, least fully conscious introjects.

Brief Critique of the “Bad Mother” Concept; The Patient’s Illness is Continually Being Interpersonally-Maintained in Current Living

Much has been written, by many writers—including myself, years ago (Searles 1965)—concerning the Bad Mothers of schizophrenic or borderline patients. I have gradually learned that such villainizing of these mothers underestimates (1) the importance of the patient’s identifications with the Bad-Mother components of his mother; (2) his own holding himself primarily responsible for her emerging as a Bad Mother, with his guilt and grief (as well as rage) about this being unconsciously defended against, in him, by his identification with those Bad-Mother components in her which he has been unable to cure; and, (3) the simplistic villainizing of these mothers glosses over the analyst’s own ever-alive Bad-Mother components. As I have come to see these things more clearly, there has come about a profound shift in my once-held, relatively static view of the schizophrenic, or borderline, patient as tending to be more or less crippled by traumatic events which occurred many years ago, in his infancy or early childhood. There is some truth in that, I still believe. But as I have found over and over, with borderline patients for example, how able the patient is to reproduce—largely unconsciously, of course—his early mother-child relatedness with me in the transference, as well as with persons round about in his adult living, and evoke the most lively Bad-Mother responses from me, or small-child feeling-reactions in me to the Bad-Mother components in him, I get a much livelier sense than I once had as
to the extent to which this adult patient's illness is continually being fed and maintained through the unconscious complicity of the persons, including the analyst, round about him in his current living.

To put it simply, the crazy (or borderline-crazy) patient succeeds in evoking really crazy (but largely unconscious) responses from other persons, day in and day out, year after year. He forms increments of folies à deux with many people in daily life, such that his psychosis, or borderline psychosis, receives, day after day, a great deal of verification from his external reality. A paper of mine (Searles 1972) in 1972, for example, detailed something of the extent to which a chronically schizophrenic woman's delusional experience, during the sessions, was founded upon real components in my own personality-functioning during our sessions—components which I tended to maintain out of my awareness as being alien to my own sense of identity.

In line with some of these concepts, I have found very often, if not regularly, that the borderline patient has deep-seated feelings of guilt and grief at having failed to enable his mother to be alive and responsive to him. His own long-time, large-scale inability to feel fully alive, and to feel imbued with a full gamut of human emotions, consists in large part in identification with such an aspect—a schizoid or chronically depressed aspect—of his mother, a crippledness on her part from which he had been able to rescue her only briefly and infrequently.

*The Patient's Inability to Experience a Full Range of Human Emotions; His Defenses Against Recognition of the Full Extent of This Inability*

The borderline individual’s inability, at the beginning of treatment, to experience a full range of human emotions has been reported by many therapists. These patients often show a proclivity for complexity in their lives, as an unconscious defense against the realization of the emotional shallowness of their interpersonal relationships. They are reminiscent to me, here and in various other respects, of chronically schizophrenic patients. Shortly after going to work at Chestnut Lodge, in 1949, I saw how commonplace it is for schizophrenic patients to present a loftily supercilious demeanor, to the effect that oneself and the other common swine, roundabout, could not possibly grasp the complexity of the world in which the patient is living. This kind of demeanor, I early felt, is one of the major factors keeping alive the well-known prejudice, in society as a whole, against schizophrenic patients.

My first Chestnut Lodge psychotherapy-patient, a chronically paranoid-schizophrenic young man who had made an extremely serious suicide-attempt during one of his two previous admissions there, perceived me as being (like other persons round about) a “cipher.” It became evident, in the course of our work, that he was projecting into me (and others, generally) his own subjective emptiness, deathness, impoverishment as regards emotions. But what makes this so difficult to deal with is—as I have seen innumerable times since then—the fact that such a patient is not only projecting; he attunes himself to those areas in oneself which really do tend to qualify one for the designation of cipher. Society as a whole tends to hate schizophrenic patients because the latter are attuned, with such hawklike accuracy, to the felt-deficiencies in society.

To return to borderline patients, not only an investment in complexity, but also (and by the same token) an investment in the gratifications of subjective omniscience are commonplace features. Time and again, there is an implied, “I told you so; I foresaw this and tried to prepare you for it” message from the patient, as his only identifiable emotional
response to an event which, for a person with the usual range of human emotions, would be the focus for diverse and intense feelings.

Typically these patients are largely enigmatic—sometimes maddeningly so, over the years—as regards any feelings identifiable to the listener (the analyst), even when (or, probably more accurately, especially when) speaking of some event or situation which the listener feels must be the focus of all sorts of emotional reactions on the patient's part. One such woman began a session by saying, in a submergedly somewhat awed, frightened, but mainly—as usual—affectively enigmatic voice, "Feel like I'm in a whirl of activity, like being on a merry-go-round—going out every evening, ... the Clinic [where she is working as a nurse] is frantically busy...." She spoke, in the next few minutes, of many, many activities, largely professional but also social ones, and, in the notes I was making behind the couch, I summarized my best impression that "It is predominantly impossible to know what patient's feeling tone is, about all this."

Some borderline patients are able to experience a certain few emotional bands, as it were, on the spectrum of human emotionality. One woman, for example, said,

"I don't feel sadness; sadness isn't really something I feel.... I understand devastation and I understand rage and I understand terror; but I don't know the milder forms [she had referred to sadness as being a mild form of devastation]. ... When I feel irritated or annoyed, I don't really feel those feelings; what I feel is rage.... I can either feel complete devastation or nothing. I don't have those in-between states; they just never had a chance to develop. The others were too strong. So it's either those strong states or nothing, and most of the time it's been nothing...."
mother dwelt inaccessibly in her own world of fantasies. It is surely no coincidence that the patient herself developed really remarkable capacities for being both shocking and insulting in her subsequent interpersonal relationships.

The Patient's Inability to Accomplish Grief-Work

The borderline individual's inability (without therapy) to accomplish grief-work is both one of the major diagnostic criteria for the borderline state, and is, necessarily, one of the major tasks of the therapy. The Mitscherlich's (1975) volume, The Inability to Mourn, and Volkan's (1976) Primitive Internalized Object Relations are relevant to this general topic, as is Volkan's (1981) Linking Objects and Linking Phenomena, which I read in manuscript form, in connection with his having invited me to supply a foreword to it. But, so far as I know, without my having done any thorough review of the existing literature, most of what follows is original with me.

The inability to grieve is, for the borderline individual, one of the most difficult areas to mask, in his larger, over-all difficulty in participating fully in the emotionality which daily human living calls for. The death of a parent, for example, tends, as do few other daily-life events, to highlight, for all to see, how largely unable he is to have the feelings which other people have, and which they expect him, now, to manifest. It usually requires much work, on the part of both participants in the therapy, for the patient to become able to reveal openly his difficulties in the realm of genuine emotionality—to be able to say, as one man said after some years of analysis, "I don't feel sorrow. I've never felt sorrow."

The Patient's Amnesia

In my experience, one of the reliable criteria for the patient's being in a borderline condition is his manifesting, usually in the initial, history-giving interview, a striking loss of memory—amnesia—for the events of his childhood. Typically, there will be stretches of years, somewhere between the ages of, say, three and eighteen, for which he will have few, or even no, memories. I do not mean that he will have few or no memories for that whole 15-year span of time I mention by way of example; I mean, rather, that somewhere within that time span there will be one or more stretches of years (say, two or three or four or five years) for which he will have essentially no memory. This stands in striking contrast to the predominantly neurotic individual's memory, at the outset of treatment, for his childhood.

In the instance of one's work with the borderline individual, it is typical, by the same token, that even after years of one's working with him, one still has only a relatively fragmentary and clouded picture of the chronological events of the patient's childhood and adolescence, and of the personalities of the other family-members. The more powerfully-maintained is the patient's amnesia, the more powerfully, of course, is he unconsciously reliving his childhood in the transference-relationship with the analyst. But the analyst often feels greatly hampered, nonetheless, in attempting to identify the nature of the transference, and to locate it in its proper era in the patient's developmental history, for the reason that he, the analyst, still has so little of consciously-recalled history from the patient, to serve as a kind of framework upon which the transference-derived information can be based. Here, instead, the transference-derived information must serve to a large extent as the framework, or foundation, itself.
At the most difficult times in my work with borderline patients, I find that part of what is most stressful, for me, is that I feel unable, for weeks or possibly even months at a time, to locate what is happening between the patient and myself in either his developmental history or my own. As a beginning psychiatrist and still, a few years later, as a beginning psychoanalyst, I assumed (as did, I believe, my peers in training) that if one's work with one's patient reminded one very much of something from one's own childhood, it shouldn't; this was to be regarded as one's needing more of personal analysis. But in my work with difficult patients, now many years later, I find it very helpful if the stressful and confusing interaction with this disturbing patient, here, is reminiscent to me, at least, of scenes and events of my own childhood, even if not reminiscent to me of the patient's childhood as I have heard about it from his consciously-recalled memories of it, or from what we both have learned together of his childhood, thus far, from transference-manifestations earlier in our work together. It seems to me that, on the other hand, when psychoanalysis or psychotherapy is going well, the analyst (or therapist) can readily perceive what is happening both as part of a pattern of the patient's life on the one hand, and as part of the pattern of his own life on the other hand.

In the above-mentioned stressful instances in which one cannot sense wherein this disturbing interaction is rooted either in the patient's past or even in one's own past, I think it erroneous to assume that if only one were to gain more of personal analysis of one's past, all would become well. I believe, rather that the analyst's experience, here, is (as it proves to be so reliably, time after time) in the nature of valuable, and highly specific, information about the patient's past. My belief is that what the analyst is experiencing, here, had a counterpart in the experience of one or both parents of the patient.

That is, it seems to me to have been typical, in these so-amnesic borderline patients' childhoods, that the parents, in their rearing of this child, were trying largely to forget their own pasts, rather than to use these, in any well-integrated, freely remembered and reminisced-about, fashion as a guide or context for their relating to him. Typically, such parents have so much of un-integrated hatred and un-worked-through grief, disappointment, hurt, and so on, from their own childhoods, that they cannot consciously put their past largely in the past, but instead to a large extent relive, unconsciously, their past with the patient installed, often at a very tender age indeed, as the parent's transference-mother or -father.

So, to repeat now, I suggest that the analyst, at a time when he cannot see meaningful historical antecedents, either in his own past or in the patient's past, to the stressful interaction in which he and the patient are caught up, is provided, thus, with a glimpse into the inner life of the patient's mother or father, whose own childhood was rendered largely unavailable to her or him, in this rearing of their child, by the unconscious defenses of dissociation and splitting.

The patient's amnesia serves as an unconscious defense against, of course, all sorts of negatively-toned emotions—guilt, fear, sadness, grief, and so on. It serves as a defense against murderous feelings; these patients can be seen to have murdered, unconsciously, large areas of their own pasts, for the reason (among others) that the recall of what actually transpired during those areas brings with it the experiencing of murderousness (toward parents, siblings, and so on) of formidable intensity. In this sense, the patient's previously-maintained amnesia has served to protect the parent's (for example) life.

Similarly, the amnesia may be found to have served both as a defense against, and a symbolic form of, suicide. In
the instance of one man, I had come to realize, after some years of working with him, that two of the areas of his remembered past belonged in chronological sequence, whereas these had been discrete and unrelated in his own memory of them. I pointed out to him this seemingly simple fact, and then for several days, afterward, I had reason to fear that he would suicide; his having kept these, unconsciously, as chronologically non-sequential had protected him, heretofore, from intense guilt, concerning the events of these areas of his past, of near-suicidal proportions. My technical error, here, probably had mainly to do with the fact that my interpretation was not primarily, if at all, a transference-interpretation, such that he had reason to feel abandoned, by me, to deal with areas of his past with which he had been unable, as a child, to cope, and with which he still could not cope. That experience served as still another reminder of how essential it is to make one’s interpretations in the form of transference-interpretations, and, by the same token, of how essential it is, as regards the patient’s amnesia for his own life-history, that this amnesia be explored in terms of his difficulties in remembering the developing history of the therapy itself.

In this connection, it is typical, in the transference-countertransference situation involved in one’s work with such a patient, for either the patient or, oftentimes, oneself, to have striking difficulty in remembering, reasonably fully and in sequence, the events which have occurred over the months or years of the therapy thus far. In my work with any patient who tends not at all readily to see connections between the present session and earlier ones, I find it of interest to notice at what point, in this present session, something he says reminds me of the preceding session or, perhaps, of some much earlier part of our work. More often than not, within a few moments I find occasion to share this with the patient, and I find patients receptive enough, to this kind of therapeutic intervention, to encourage my doing so more and more freely. The patient, in this instance, tends to feel more appreciated (by this evidence that the therapist remembers) than narcissistically wounded and relegated to his own pre-treatment past, as in the example of the non-transference intervention cited earlier.

Another form of the patient’s amnesia is this: he recalls most of the family-members relatively well, and is able thus to give the analyst a relatively good, three-dimensional image of what each of those family-members was like; but there is one family-member whom he scarcely ever mentions. I have learned that this is a reliable indication that the family-member in question was quite the opposite of having been relatively insignificant in the patient’s upbringing. The fact of the matter, as I have found time and time again—always, nonetheless, to my considerable surprise at first—is that the patient is so fused with that family-member that the latter exists very little as any separate object in the patient’s remembered past.

As one example of this, a woman referred not infrequently, for years in her therapy, to “my sister,” whereas she had told me at the outset of the treatment that she had two sisters, both older than herself. “My sister” always referred to the eldest sister, an idealized mother-figure to the patient. Only after years of treatment did it start to become clear that the patient was much fused with the other sister. It became clear in retrospect, that during the frequent largely-silent sessions we had had, I had represented this intensely ambivalently-regarded sister in the transference. Similarly, this helped to explain why the patient, in speaking of her marriage, would usually say “I,” rather than “we.” In marrying her husband, she had married, unconsciously, her next older sister as well. Many of the difficulties which “I” had in the context of the marriage actually belonged to this transference-sister husband of hers. Thus, when she
would speak of money-worries which, clearly, her husband as well as she was facing in their marriage, she would say only what "I" felt about them, and would often leave me wondering what her husband's feelings were about these matters. But it developed that she was as little individuated from him as she was from the next older sister, and from me in the treatment-situation.

Defensive Functions of the Patient's Vengefulness

Vengefulness is an important aspect of the borderline individual's personality-functioning, although hardly to be regarded as a specific criterion of the borderline state. His areas of amnesia serve, as I have already indicated, as an unconscious defense against murderous vindictiveness, among other emotions. He who has not yet become mature enough to forgive must forget, as a poor substitute for forgiving. In my paper in 1956 entitled, "The Psychodynamics of Vengefulness," I emphasized the defensive functions of vengefulness, particularly with regard to repressed grief and separation-anxiety. Many borderline patients show a tenacious, rageful determination to "go back and show 'em!"—to go back, that is, to some particular earlier place and time and prove to "them" (parental family-members, schoolmates, or whomever) that they had failed to appreciate, at all fully, the patient's good qualities—or, more adequately put—to make them see that the patient was not the person they thought he was, but rather the so-different person he is convinced that he is, and was, in essence, then.

The analyst can readily find evidence—though it may take long to interpret effectively to the patient—that the patient, in this vengeful determination, is defending himself against feelings of grief and separation-anxiety vis-à-vis those earlier persons and settings. But it is useful, in addi-

tion, for the analyst to see that the patient's vindictiveness represents an attempt to overcome an underlying sense of discontinuity in his personal identity. That is, the patient himself cannot at all fully accept his more recently-acquired personality-aspects and, in his burning determination to go back to that earlier time-and-place to which he is so emotionally-fixated, he is endeavoring to establish a stronger sense of continuity of identity. He would try coercively to make "them" accept those attributes of himself which, to a significant degree, he himself has not been able to integrate well into his over-all personality functioning. In order for him to become better integrated, and therefore no longer vengeance-oriented, he will have to accomplish more of working through of grief (and so forth) regarding those persons and places in his childhood and youth.

One can see here, too, relatively readily, the role of his projection upon "them" of his own tendency to depreciate the positive qualities of other persons. It is unlikely that they were actually as depreciatory of him, at that earlier time, as he, now, in his need to keep his grief (and other positively-based feelings) so largely dissociated, is depreciatory of them.

A man said, "I have no more resemblance to myself twenty years ago today than I have to you—just a completely different person—no sense of continuity—my present life began four years ago when I married Edith. A few little things remain [from his earlier life]; I rediscover a little thread—recently [for example] I found myself rocking, and realized that I had done that for years as a child."

A paper in 1980 by Horowitz, Wilner, Marmar, and Krupnick entitled, "Pathological Grief and the Activation of Latent Self-Images," is relevant here. These authors describe states of pathological grief in terms of the reemergence of self-images and role relationship models that had been held in check by the existence of the deceased person.
Now that the relationship with that person has been lost, the patient becomes immersed in a review of his repertoire of self-images and role relationship models. The authors describe that the review—in contrast with that found among relatively normal persons in states of bereavement—becomes unusually intense and interminable, or excessive controls prevent review of activated role relationship models so that mourning is never completed.

As the patient’s amnesia begins to lift, it is striking that, on occasion, it will lift so fleetingly that he will remember, for a few seconds, a flood of previously-forgotten memories, only to find they are covered, once again, by the amnesia at the end of those few seconds, and he feels entirely helpless to recapture them and report them to the analyst. This kind of thing lends itself, of course, to his sadistic tantalizing of, and sexual teasing of, the analyst (an aspect of their interaction which I shall describe further in a few minutes), but at a level which may be genuinely unconscious, in the patient, for many months or even years.

**The Patient’s Difficulties in Realizing That a Dead Parent Is Not Merely “Dead” (Psychologically Unrelated) Once Again**

It is impossible for a patient to grieve the loss, through death, of a parent who had been, throughout the patient’s experience with him or her, in such a state that the patient never really did “have” the parent in any case—never was, more than fleetingly, in any full relatedness with him or her. It is relatively simple in those instances in which the parent was physically away nearly all the time; I am referring to those far more frequent, and much more difficult, instances in which the parent had been physically present relatively much, but psychologically largely absent, nonetheless.

These parents, collectively, were psychologically absent for a great variety of reasons. Some few of them were recurrently frankly psychotic. Many were chronically depressed. Many had, themselves, personalities of an “as-if” (H. Deutsch 1942), or other variety of borderline, nature. In ordinary rather than psychiatric pariance, one cannot go through an average-normal, healthy process of grieving the death of a parent who had been nearly always, throughout one’s childhood and adolescence, emotionally remote, or preoccupied with one had no way of knowing what, essentially dead to the living events in which the others in the family were participating.

The parent whose own ego-functioning was poorly integrated (whether of a borderline or schizoid nature, for example) had so much of unintegrated-loss feelings from his or her own parental-family past, that he could only rarely emerge into relatively full relatedness in the marital family. This is entirely analogous with one’s finding that the patient, himself, can only rarely enable one, for many months of the work, to feel, strongly and immediately, what the patient’s childhood family-situation was like.

The analyst sees, in the patient’s identifications with the parent in question, the kind of non-relatedness which had been relatively predominant in the parent himself or herself. I could see, for example, in one woman’s reaction at the beginning of a session, a glimpse of how removed her mother had usually been. She reacted in an unusually startled way when I opened the door to the waiting room to indicate for her to come in; she seemed startled, fearfully, out of deep and anxious preoccupation. In the opening moments of the session itself, after she had assumed the couch, she was saying, “. . . Feel like my mind is somewhere else this evening—not sure where. . . .” She spoke in a tone here, as usual, that was enigmatic as regards any affective quality. I had much evidence, by now after years of her analysis,
to know that her now-dead mother had been predominantly like this in life.

In a case discussed in the preceding chapter, I mentioned that

...Another borderline woman, whom I interviewed before a group of psychiatric residents, replied, when asked her something about her mother, that "The first thing about my mother is that she's dead," and although this was literally now the case, several of the residents present had the sense, as did I, that the patient had perceived the mother so even while the latter had been alive. When I asked a borderline man, during one of his analytic sessions, whether he had ever confided in his much-elder sister anything of the area of concern which he was presently exploring, he reacted with a degree and kind of shock which helped me to realize that, for him during his childhood, his sister had been psychologically dead, and that many of our more moribund sessions had to do with his transference to her as being that "dead" sister.

Another man, whose father had died when the patient had been 15, said, in describing a recent telephone conversation in which he had spoken in a calming way to his anxious older brother, "I think that's what my father woulda done had he lived." This man continued, for years in his analysis, to idealize his dead father. But I knew, on the basis of abundant material, both from the patient's own conscious memories and from the unfolding of the transference, that the father had been highly sequestered from the emotional life of his marital family, and, apparently, much more immersed in the long-gone life of his own childhood family. When the patient made the brief statement I have quoted, although he said it without any discernible, conscious anger or contempt toward his father, he nonetheless said it in such a tone as to convey the unconscious meaning, "I think that's what my father woulda done had he ever lived." This patient was vulnerable to feelings of fearful unsureness, for years before and after the beginning of his analysis, as to whether he himself existed, and this symptom proved to be based largely upon his being assailed, unconsciously, by his identifications with a father who, in his own experience with him, never really and fully existed, in the interpersonal-relatedness meaning of that term.

The Patient Who Chronically Teases the Analyst

In this connection, the chronically-teasing variety of patient merits at least brief mention. An appreciable percentage of borderline patients behave, for year after year in their analyses, in a predominantly teasing fashion, as to whether they are ever going to become fully committed to the analysis, and thus enable the analyst to feel able fully to function as analyst to them, or not. I have had so many sessions, by now, with such patients as to have developed the conviction that one of the varieties of hell, for me, will be a realm wherein, all day long, day after endless day, I will be attempting to analyze patients who report dreams, and report abundant associations to those dreams, and all that kind of thing that "good" patients do in analysis—but do so in such a teasing fashion that I almost—but never quite—have acquired the necessary material for making an interpretation of the transference.

I have developed increasing compassion for these torturers insofar as I have discovered, with one or another of them, evidence that this sadistically-teasing behavior of his or hers is based largely upon identification with a (now dead, in most instances, but significantly ungrieved) mother.
or father who, throughout the patient's upbringing, has genuinely functioned as a parent in no more than a teasing degree. The father, for instance, had teasingly held out the hope, year after year, that one day he would really become a father to the patient. By the same token, in the transference-relatedness, the patient (who from the analyst's view is himself so teasing) finds a basis (and not only through projection of his own difficulties in this regard) for feeling tantalized analogously, year after year, with the hope that the analyst will one day, at long last, come forth and commit himself fully to being the analyst to him.

The Patient as the Parent's Transference-Mother or -Father

Typically, the borderline patient was unconsciously perceived, by the parent, as being the personification of the parent's own unintegrated past. Such a parent, who manifested this "transgenerational" transference to the child, one who had been unable to work through the loss of (among other persons and places, and so on) the parent's own parents. Thus, a mother who has not been able to work through the loss of her own mother will tend to form a transference to her child as being that mother (the child's actual maternal grandmother). The more ill we find the adult borderline patient to be, the more justified we are in assuming, until proven otherwise, that this kind of thing happened strikingly early in his childhood. What I am describing here is even more strikingly true, and began at an even more strikingly early age, in the childhood of the person who later becomes not borderline but chronically psychotic.

Probably there is no more basic determinant of the borderline patient's vengeful desire to "go back and show 'em!" than his need to somehow make his parent realize and accept that he—the patient—has long been functioning as psychological parent, rather than child, to the biological parent—and to achieve this realization at an internal level within himself, in terms of introjects and identifications involved in his sense of personal identity.

The Patient Unconsciously Perceives the Analyst as Living Vicariously Through Him; Acting-Out

Such a parent as he or she whom I am describing as typical of those of borderline patients—the parent, that is, who has never achieved any full individuation from (= loss of) his (or her) own parent, but who forms a symbiotic transference with the child as a means of perpetuating the parent's childhood-symbiosis with the parent's own mother or father—typically does much of vicarious living through the child (from whom the parent is so incompletely differentiated) as the child is growing up. Thus, the child is given to feel that it is not really his own life which he is living, but rather that of the parent.

When such a child becomes then, in due course, an adult borderline patient in psychotherapy, he typically coerces the analyst, naturally enough, into feeling that he, the analyst, bears the primary, basic, and essentially total responsibility for the way the patient's life now goes. The patient lays his career-failures, for example, at the door of the analyst in such a manner that it is difficult, indeed, for the analyst to extricate himself from the guilty conviction that the patient's failure to thrive is basically due to the analyst's own presumed malevolent orientation toward him. One cannot help, after all, genuinely hating such patients. By the same token, much of such a patient's "self"-injurious acting-out, of various forms, is based upon the patient's having introjected the hated parent-figure analyst whom the patient assumes
(in light of the unconscious transference) to be unwilling and unable to let him, the patient, have his own individual life. Thus, it is this hated, internalized parent-figure analyst with whom the patient is injuring in his “self”-injurious acting-out, whether in suicide-attempts or whatever.

Splitting

Splitting is, as has been described by Kernberg (1975), Giovacchini (1975), Masterson (1976) and other writers, one of the major defense mechanisms characteristic of borderline patients. I shall limit myself, here, to mentioning two points which, so far as I am aware, these previous writers have not dwelt upon.

To the extent that the patient is still invested in an infantile-omnipotent orientation, he tends to experience grief not as being a natural part of human living and dying, but rather as something which perceivedly omnipotent beings are attempting to inflict upon him. As one works year after year with a number of such patients, one learns to what a striking degree this was indeed true in their childhoods. One sees this through one’s being on the receiving end of those split affects and transference-images which derive from the patient’s childhood experience with a parent whose ego-functioning involved much of splitting.

Specifically, one finds that the patient will sadistically hold over one’s head the threat, year after year, of his separating himself permanently from one—the threat of his leaving, one of these days, and never returning. His splitting is playing a major role in this for the reason that he is conscious of the liberating, and other positive, aspects of the prospective separation, but projects into the analyst his (the patient’s) own feelings of reluctance, loss, and grief, which such a separation holds for him. For the child who grows up at the hands of a parent who thus splits, any healthy grieving would be a genuinely inappropriate response to separations from, or threatened separations from, such a parent, for, as one sees in one’s work with the patient himself, any revelation of anguish on one’s own part feels to be serving no purpose beyond giving gratification to the patient’s sadism—rendering his sadism effective.

A woman was in analysis for a number of years, dwelling almost exclusively upon daily-life events, before she started giving me glimpses of her extraordinarily shockingly-deprived (in many regards) childhood, a childhood which heretofore had been shrouded largely in amnesia. These memories were so shocking to me, to hear, that I felt at first that it had been primarily my own inner limitations which had prevented her from conveying to me, much earlier, readily-available memories of her early years. But I realized, as we went on, that these memories were available to her, herself, only as frequently as I, and the relationship between her and me, were strong enough to stand the emergence of these disturbing memories from their long dissociation. After her having remembered, during a session, and reported to me some further details from her impoverished daily life as a child, she said, “You didn’t know it was so terribly poor, did you? The more I think about it, I guess it was...” Another way of thinking of this is that her long-maintained denial, of the extraordinarily deprived, and in other regards traumatic, aspects of her daily life as a child, was now being eroded through by our analytic work.

Still, for many months further in our work, the memories of her childhood emerged only infrequently, in shakily vivid fragments a few months apart. My belief is that she, during her childhood, could not stand seeing the reality of her life any more continuously and fully than I was providing able, now many years later in my analyzing of her, to stand seeing it.
To Grieve Effectively the Loss of a Relationship, One Must Have Been Involved Genuinely in the Relationship

The loss of such a childhood situation cannot be grieved if the situation was so bad, for the patient and probably for all the other family "participants," that they collectively were not really fully in it. Instead, they—and certainly this must have been true for the patient herself as a child—were shrouded in a cocoon of denial such as prevailed in the patient during the early years of our work together.

The principle which I have stated here, namely, that in order to become able to grieve the loss of a situation, one must first have been really in that situation, is one which I had thought of several years ago, as regards the optimal timing of any patient's discharge from a psychiatric sanitarium. That is, it became apparent to me that, in order for a patient to become able to leave the sanitarium constructively, he or she must first have come to be in the sanitarium, psychologically as well as physically. The patient who keeps himself convinced, by various unconscious denial mechanisms, that he has never really accepted his being here in the sanitarium will be minimally prepared to integrate the inevitable unconscious loss-feelings that his moving out of it will bring. His inability, then, after discharge, to mourn the loss of the sanitarium will tend powerfully to lead him to act out in ways which are designed, consciously, to restore him to the sanitarium which he has not really failed, throughout, to hate, despise, and refuse to accept.

As regards the sporadic, fragmentary, and subjectively unpredictable nature of the amnesia-ridden patient's memories of disturbing events and situations in his earlier years, there is a counterpart in the analyst's own tendency, largely unconscious, of course—to maintain amnesia for particularly shocking revelations from the patient earlier in their work. For example, in one instance of father-daughter incest, and in another of a mother's having killed her infant daughter, the therapist whom I supervised in each of these instances was struck by his own managing to forget, for relatively long periods in the work with the patient, what the patient had suddenly remembered, and confided to him, earlier, of that shocking event. The therapist would be shocked anew, now, to hear of it as if for the first time and to hear, further, some additional details of it which had managed to escape from the patient's own unconscious denial that it had happened.

Incidentally, always to be kept in mind, in such instances, is the possible additional factor that both participants in the therapeutic interaction are displacing into the past a sense of shock which is stemming, at an unconscious level, predominantly from something they are doing to one another in the present session.

By way of discussing another manifestation of borderline patients' splitting, I want to mention that frequently in my work with a number of such persons, when the patient says, at the beginning of our first session following an interruption in our scheduled meetings, "I missed you," I get a fantasy of a disappointed sniper. The gentle reader might, of course, assume that this is merely further evidence of a paranoid stance on my part, in my relationships with my fellow human beings. Surely such a patient, who is struggling to prove to himself that he is a predominantly loving person, and struggling to maintain his more hostile attitudes in a state of dissociation, would have the analyst think himself basically paranoid for having such a fantasy.

But I have had a sufficient wealth of experience with feelings of indubitably genuine missing and being missed, in both professional and personal relationships, so that I can regard as reliable analytic data my fantasy of the patient as being a disappointed sniper. Sooner or later, I report this
fantasy to the patient, and I find that my doing so, although inevitably somewhat jolting and wounding to him at first, enhances our collaborative work upon the matter over the course of time. The analyst cannot help the borderline individual to achieve genuine rather than “as-if” emotional relatedness unless he, the analyst, can deal with spurious emotionality as being such. One such woman, who for years in our work had been hampered, in her conscious efforts toward loving relatedness with people, by this split-off, disappointed-sniper area of her ego, came to say, “I was thinking yesterday, ‘I miss you like crazy.’ But then I also thought, ‘I miss you like poison.’”

Grieving Regarded Unconsciously as Being Innately Murderous

I believe, but cannot prove, that there is an important factor, in the patient’s dissociated disappointed-sniper self-image which I have postulated here, which goes beyond the fact that his loving impulses are still opposed by unintegrated murderous hostility toward the analyst. This factor, I believe, consists in his unconscious belief that grieving itself is innately murderous to the one whose absence one is grieving. That is, I surmise that the patient is dominated, at an unconscious level, by a primitiveness of thought which holds that one’s grief is at least as much the cause, as the result, of a beloved person’s death. I have little doubt that cultural anthropology would provide many examples of this kind of thinking among primitive peoples, and I have seen clear-cut evidence of it in my work with a chronically schizophrenic woman whose long psychosis began shortly after her mother’s death—a death which, as with death generally, the patient cannot accept as a reality. Significantly, this woman, who still feels a loving-god-like responsibility for all her
good objects, past and present (including, of course, her mother), has never been able openly to weep, and has long been troubled by that inability. She is convinced that if one really loves one’s mother, she (the mother) will never die.

Sadism as a Defense Against Feelings of Loss

For some years in my work with a borderline man, to a striking degree, and to a perceptible degree in my experience with a number of similar patients, I have felt that it was in the moment of my signaling, punctually, the ending of the session, that I was earning my entire fee for the session. One aspect of my feeling, in indicating the end of the session, is that I have felt so irrelevant and useless, throughout the session, that the patient must wonder how I can bear to end the session and leave it at that for today. Not uncommonly, the patient will give one some glimpse that this is indeed how he feels at this moment; it is even worse when he leaves one entirely at the mercy of one’s own thwarted self-expectations.

I have found it helpful to see the important role which the patient’s sadism is playing in the events which now require me to end the session in this context. With other patients, I am conscious of their leaving the session in a manner which bespeaks a sadistically abrupt, and unnecessarily total, withdrawal of feeling before leaving the room. In many other instances, I have noticed that the patient’s free associations, in the closing couple of minutes of the session, will contain a sadistic-depreciatory thrust toward the analyst. On the other hand, this last-mentioned phenomenon can be seen as an unconscious, sadistic defense against any genuine loss-feelings, at the ending of the session, on the part of both patient and analyst. That is, the patient may not only be minimizing, thus, his own loss, but also protecting
the analyst from feeling more of loss than of relief at their imminent end-of-session separation.

The Relinquishment of the Patient’s Illness
Involves a Mutual Loss-Experience for
Patient and Analyst

We analysts tend to feel guilty at finding any gratification in a patient’s psychopathology, particularly if that psychopathology is very severe; we tend to fear that we are morbidly fascinated with illness, and that we secretly prefer it to health. But in my experience, both in my own work as an analyst and in my supervisory work, it is necessary that the analyst come sufficiently to share the patient’s own gratifications in the latter’s illness so that he, the analyst, can share the patient’s heretofore unintegratable (largely because of his interpersonal isolation) feelings of loss in gradually giving up the illness. To put it in another way, the analyst must first help the patient to experience to the full the gratifications of the illness, through the analyst’s own having dared, as it were, to permit himself to become aware of and accept such gratifications. Then the patient’s grief-work, in the process of giving up the illness and all that it has represented to him for so many years, can be a genuinely shared experience, shared with the analyst. I do not see how any successful grief-work can have been otherwise than shared with someone, or ones. In the typical psychiatric and even psychoanalytic teaching of years ago—and it still is widespread, indeed—the therapist was trained to help the patient to “get over” the latter’s illness without the patient’s or anyone else’s—least of all the therapist who was trying to help him to “conquer” the illness—becoming aware of the positive meanings which the illness held, unconsciously, for the patient, and the genuine grief which must be worked through, therefore, if the patient were to become really “free from” the illness.

One of the principles which I am suggesting again and again, in this chapter, is that for one to become able to grieve effectively the loss of something—whether a relationship with another person now dead, or one’s life in a sanitarium or mental hospital, or a mental illness—one must have become able to know and accept, first, that one was really involved in it. Concerning the working through of the loss of one’s illness, my paper, “Transitional Phenomena and Therapeutic Symbiosis” (Searles 1976) is relevant. There I suggest that in effective psychoanalytic therapy there is a phase in which “the patient’s symptoms have become . . . transitional objects for both patient and analyst simultaneously.” This gives some glimpse of how deeply mutual is, in my view, the shared grief-work in the patient’s relinquishment of his illness.

A borderline man, able to finance no more than once-a-week therapy, described in one session, after about one-and-one-half years of our work, some aspects of his parental-family life which were so fascinating to me, so enthralling in their schizophrenogenic-family aspects, that later on in this session, or soon after it, I wondered how much in the way of anxiety- lest-the-patient-suicide, and anguish about the setting of limits, and so forth, does an analyst realistically have to accept in order to pay, as it were, for the tremendous gratification one derives from working with borderline patients. His so-enthralling description, to which I refer, occupied no longer than about two, and certainly not more than five, minutes in a session largely devoted, as were most of his sessions, to present-day, daily life events, far from his parental home of years ago.

Then in a session on the following day with a supervisee who was presenting to me, each week, his work with a severely borderline woman, I heard from him a detailed
description of a beautifully ambivalently-symbiotic session which he had had with his patient in recent days, and the supervisee and I agreed as to the guilt-engendering (for the typical therapist) aspect of such tremendously symbiotic intimacy. Then I told him that I had wondered how much one must expect to have to pay (in terms of anxiety, and so forth) in working with borderline patients (and others comparably ill) for the gratifications which one derives from the work; I told him my impression of there being unconscious guilt for which one has to atone by so paying. He immediately felt the idea to be a valid one. He himself had had a very considerable number of years of experience in working, predominantly in a hospital setting, with severely borderline and schizophrenic patients.

My best impression is that such guilt as I have mentioned, here, functions mainly as an unconscious defense against the analyst's (or therapist's) feelings of loss as the patient improves and the more primitive, symbiotic mode of relatedness is largely relinquished. Such feelings of loss, for the analyst, are of a piece with the earliest feelings of loss in his own life. He must "pay," eventually, for the intense gratifications which he derived from (for example) his transference-and-countertransference-based participation in such a patient's parental-family symbiosis, by coming to experience, with the patient, the loss of that symbiosis—a loss inseparable from the loss of the symbiotic modes of relatedness in his own early parental family.

**Premature Termination: The Stresses Which This Places upon the Analyst**

One of the most stressful aspects of the analyst's work with borderline patients is that, when the treatment ends—as it very often does—prematurely, the analyst, in finding himself experiencing, then, little of the phenomena of healthy grieving—but experiencing, instead, only relief, admixed with unappeased hatred, and dread or paranoid fear of the patient's returning—tends to find this to be one more important piece of evidence, for the nth time now, that he, the analyst, is basically an unfeeling son-of-a-bitch. That is, for him as for such patients, the test of whether he is capable of grieving is felt to be the acid test of whether he can feel anything. An analyst can adapt to a rare treatment-outcome of this sort; but if a considerable percentage of his patients are borderline patients, he finds that such outcomes are not rare, and the accumulating effect of such outcomes tends progressively to undermine his confidence in his own ability to feel loving feelings, and to be capable of grieving. Keep in mind that I am referring, here, to those relatively frequent instances in which the borderline patient breaks off treatment in a setting of predominantly negative transference, convinced of the analyst's malevolence and showing, himself, no sign whatever of any felt loss of this analyst who in actuality has gone through a great deal with him in the preceding months or years.

What I am describing here links up with, although in reversed form, the experiences which patients have when their analyst, himself denying unconsciously any feelings of grief or loss, is about to go off on his vacation and is giving the patient to feel that this forthcoming separation is a kind of acid test of the patient's ability to grieve over separations, and more largely a test, therefore, of the patient's ability to feel any valued human emotion.

**The Patient's and Analyst's Defenses Against Fusion with One Another**

One of the fear-of-fusion characteristics of many—although by no means all—borderline patients consists in the patient's mocking, derisive, ironic, scornful typing, or classifying, of
other persons in terms of one or another part-aspect of the other person, often a part-aspect of which the latter is largely unaware. The patient in whom this is a prominent defense possesses, typically, a devastating ability in thus writing off persons round about him, in daily life, with epigrammatic, satirical characterizations of those persons, leaving the latter fixed, as it were, like so many various flies in amber, or oddballs in a wax museum of freaks. Such patients have proved, one after another, so formidable to me, for many years, that I have been slow to realize that this is a major defense, for such a patient, against his own underlying tendency to confuse all persons, round about, with one another—to become, that is, helplessly unable to differentiate among them.

It is in such a patient’s transference-perceptions and -responses of this nature that he is at his most formidable, of course, for the analyst. Again speaking of my own experience with such persons, I find time and again that he will react to some part-aspect of me—a facial expression, a gesture, an intonation, an article of clothing, or whatever—as comprising a complete personification of me, and of me at my most socially uncomfortable, schizoid, hopelessly inadequate self. Typically, such patients react to aspects of oneself which are at the fringe of one’s conscious sense of identity—aspects of oneself which one struggles to disavow. If the patient were reacting to aspects of oneself which were even farther from one’s awareness, presumably one could more readily dismiss the slings and arrows.

This attribute of the borderline patient is all the more difficult to meet, technically, for the reason that this defense is predominantly an unconscious one in the patient himself: at a conscious level he is largely unaware of emitting any rather steady barrage of roundabout needlings of the analyst, and is far from feeling that he has the analyst chronically at his mercy. In my work with one such female patient with whom I have met for more than two years, a typical session involves her making some dozens of skillfully derisive characterizations of my various oddities, but nearly always in terms of her speaking of these as being displaced onto various persons in her daily life, present and past, and my attempts to invite her collaboration, in exploring these tantalizingly disparate components of negative transference, and finding something more coherent and therefore meaningful in these, serve only to make her feel recurrently rejected and to feel, for the nth time, discouraged at my taking everything personally.

It goes much better, in my work with this woman, when I can hold my tongue, and perceive these many indirect barbs as being defensive, on her part, against her longings fully to identify with me, fuse with me (with me as the personification of her early mother, in this instance, for the most part). There have been times of especially helpful insight when I have realized that, in her being superficially most formidable mocking in her characterizations of her husband, for example (= myself in the transference), she is desperately grasping, at a deeper level of awareness, at these straws (these derisively-perceived part-aspects) to keep from drowning in undifferentiatedness from—fusion with—me. She manifests, it seems to me, essentially the same defense as that manifested by society collectively against their fear of oneness with the schizophrenic segment of the population: the part of the society labeled as sane tends powerfully to react to schizophrenic patients, collectively, as being essentially alien, nonhuman.

Such borderline patients project this motive upon the analyst, so that when the latter attempts to single out for interpretation some aspect—inevitably only a part-aspect—of the patient’s functioning, the patient reacts as though the analyst’s main attempt is to ridicule and distance him. My own impression, however, is that more often than not there
is appreciable accuracy in such an impression on the patient's part—that is, that we analysts indeed do a great deal of premature interpreting as an unconscious defense against our underlying fear of our longings to fuse with the patient.

One of my patients, a woman who manifests many typically "as-if" features, has been in analysis for several years, and it has been only relatively recently that I have found it feasible to make interpretations with any reliable and consistent frequency. Heretofore, she subjected each of my interpretations—or other comments of any sort—to such savage and persistent mockery as essentially to destroy it. She reduced it to the same undifferentiatedness, essentially, as she basically did, throughout each of the sessions for years, with each of her "own" part-aspects, part-aspects which were based, in actuality, upon relatively superficial identifications with other persons, persons for the most part in her adult life.

On many occasions, in earlier years of our work, I felt an impulse to make transference interpretations, but nearly always restrained this urge, for either of two reasons: (1) the transference-data in her communications was so tantalizingly incoherent or superficial as not to warrant my interpreting it as yet; or (2) I shrank from committing myself to sharing the acid bath, as it were, in which she was keeping herself immersed—shrank from the degree of interpersonal exposure this would involve, for me in the act of interpreting, to her acidly destructive mockery with which I was by now only too familiar.

In retrospect, I was most useful in serving silently as a holding environment until her transference-hatred had changed (as it did, to the tune of remarkably infrequent comments of any sort from me) into a predominantly positive feeling tone between us during the sessions. My earlier-reported concepts concerning therapeutic symbiosis (Searles 1965, 1979) stood me in good stead during those years of my work with her. It is probable that she was correct, meanwhile, in sensing that my interpretations were deserving of her savagely destroying them, for I now believe that they were more unconsciously-defensive on my own part than acts of constructive interpersonal relatedness toward her; they were mainly obstacles to the development of the therapeutically necessary degree of non-verbal symbiosis between us.

Summary

The borderline patient's personality-organization renders ever-present, for him, the danger of separation and loss. He is continually faced with the threat of loss, either of his tenuously established individual identity, through fusion with the other person; or of his fragile interpersonal relatedness, through uncontrollable flight into autism of psychotic degree.

The analyst typically tends to repress or dissociate, and project into the patient, the primitive personality-components which the latter arouses in him. Much "self"-destructive behavior on the patient's part consists in his having introjected some of these most primitive, "sickest" components of the analyst's ego-functioning and, in the acting out, venting aggression upon this introject.

The patient has deep-seated feelings of primary (maternal) responsibility for curing the "Bad-Mother," primatively hateful components of the analyst. To a significant degree the latter, like everyone else, possesses such components; but in addition the patient here is projecting into the analyst the former's own powerful but unconscious identifications with comparable components in his mother and other mother-figures from his childhood.

The patient's inability (without therapy) to grieve effec-
tively is but one facet of his inability to experience the full range of human emotions. This inability is defended against by fantasied omnipotence and omniscience.

Among the reliable criteria of the borderline state is the patient's striking loss of memory for large areas of his childhood. Some of the determinants of this amnesia are touched upon. It is best dealt with in the transference context, in terms of the developing history of the course of treatment itself. Typical countertransference difficulties in this connection are briefly discussed.

This amnesia is defensive against grief, separation-anxiety, and hostility of murderous or suicidal degree, and bespeaks a discontinuity in the patient's sense of identity—a poor integration of disparate fragments, from disparate developmental eras, in his sense of identity.

The interpersonal basis, present and past, in the etiology of the patient's difficulties with grieving are mentioned here. For example, a child cannot fully grieve the death of a parent who, even in life, was predominantly not psychologically there.

The parent's—the mother's, for example—having inadequately grieved the loss of her own parents, and her establishing a transference to her little child as being the reincarnation of one or another of those deceased grandparents, is another important etiologic factor in the borderline patient's typical personality-functioning, including his difficulties in grieving.

The role, in the patient's pathological grieving, of his defensive splitting is discussed, with particular emphasis upon the interconnections between grief and sadism.

The patient can relinquish his illness, eventually, only if the analyst has come to know and to cherish, to a significant degree, the gratifications of that illness, such that the loss-of-illness experience can become a mutual, shared loss-experience for the two participants. Along the way, the develop-

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